Info Session Date: _____

RWC MR #: _____

MultiCare Rockwood Clinic

BARIATRIC PATIENT REGISTRATION FORM

First Name:_____MI:_____Last Name:_____Gender: ❑M ❑F

Address:_____City:_____State:_____Zip Code: _____

DOB:_____Age:_____ Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Home Phone:_____Cell Phone:_____Email: _____

Work Phone *(if we can contact you at work)*:_____Name of Employer: _____

Primary Insurance:_____ID#:_____GRP#: _____

Subscriber Name:_____DOB:_____

Medical Claims Submission Address: _____

Eligibility or Provider Phone #: _____ Employer Group *(if applicable)*: _____

Secondary Insurance:_____ID#:_____GRP#: _____

Subscriber Name:_____DOB:_____

Medical Claims Submission Address: _____

Eligibility or Provider Phone #: _____ Employer Group *(if applicable)*: _____

Emergency Contact:_____Phone:_____Relationship: _____

Have you ever seen a Rockwood Bariatric Surgeon: ❑Y ❑N Surgeon preference: ❑Bright ❑Rawlins ❑Spitz ❑No Preference

Primary Care Provider:_____(RWC) Referring Provider:_____(RWC)

Current Weight Loss Method:_____Height:_____Weight: _____BMI: _____

Have you been diagnosed with any of the following: ❑Diabetes ❑Sleep Apnea ❑Hypertension

Which surgery interests you most? ❑Band ❑Sleeve ❑Bypass

INTERNAL USE ONLY

CM Notes: _____

Date:_____Name:_____Ref: _____

PRIMARY	Benefit	Amount Met
Lifetime Max		
Ind Ann OP		
Fam Ann OP		
Ind Ded		
Fam Ded		
Coins		
Hosp Copay		

Band	Dietary:
Sleeve	
RNY	
No Benefit	
Need Consult Auth	
Need Surgery Auth	

SECONDARY: _____

CRITERIA: BMI: _____Comorbidities: _____

INSURANCE REQUIREMENTS: _____

Psych: _____Dietary:_____Weight Loss:_____MSWLP: _____

Other: _____

CON 1 Appointment Date: _____ Time: _____ Provider: _____

Dietary Appointment Date: _____ Time: _____ Provider: _____